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FIGO INITIATIVE

Changes in the use of manual vacuum aspiration for postabortion care within the public healthcare service network in Honduras

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ABSTRACT

Honduras is one of the 17 priority countries included in the International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences. The priority category enables the country to request emergency funding to acquire services or commodities that could contribute toward achieving the objectives laid out in its plan of action. These objectives include improving postabortion care by increasing the use of manual vacuum aspiration (MVA) as an outpatient procedure with minimal human and material resources. Since the Ministry of Health lacked funding, use of the emergency fund was approved for the purchase and distribution of MVA kits nationwide to ensure continuity and the hope of increasing MVA use. Eleven hospitals participating in this initiative provided data for analysis of the outcome. These data show no increase in MVA use; however, as discussed in the article, further investigation provided valuable information on the reasons behind these results.

1. Introduction

Unsafe abortion is a public health issue in many low-resource countries that have restrictive abortion laws. In line with other Central American countries, Honduras has very restrictive laws regarding abortion [1]. Moreover, there is a legal obligation to denounce any patient seeking medical care at any clinic within the public healthcare system who is suspected of having had an induced abortion [2]. These restrictions explain the extent to which unsafe abortion in Honduras contributes toward maintaining the maternal mortality ratio above 100 deaths per 100 000 live births.

In 2008, the International Federation of Gynecology and Obstetrics (FIGO) created its Working Group on the Prevention of Unsafe Abortion. The Honduran National Society of Obstetrics and Gynecology (SGOH) is one of the member societies that has been participating in the initiative since it began. The SGOH carried out a situational analysis and formulated a plan of action in collaboration with the Ministry of Health and in accordance with some of the strategies proposed by FIGO [3]. One important item in this plan of action is to improve the care provided to women who have undergone abortion and who seek care for an incomplete abortion within the National Health Service.

Both the World Health Organization (WHO) and FIGO recommend abandoning the practice of sharp curettage in favor of manual vacuum aspiration (MVA) as the preferred method for the surgical treatment of incomplete abortion, and also recommend medical treatment with misoprostol when indicated [4,5].

Traditionally, the most frequently used technique for the treatment of incomplete abortion at public hospitals in Honduras has been sharp curettage. In 1996, several non-governmental organizations (NGOs) conducted a study to determine whether the use of MVA offered any advantages over sharp curettage when there is a therapeutic indication for its use. [6] According to international reports, comparison of these two treatments showed that costs were 60% less with MVA, mainly due to a reduction in the time needed to complete the procedure, the non-requirement for general anesthesia, and an shorter hospital stay overall. There was also a reduction in the rate of complications, particularly uterine perforation and transvaginal bleeding [6].

Prior to MVA, the patient is required to undergo counseling to enable her to give informed consent for the procedure. In addition, she must agree to initiate use of a contraceptive method of her choice after the procedure is complete and before she is discharged from hospital. This is a fundamental step that was not in place when sharp curettage was the method of postabortion care and it has significantly reduced the frequency of a second unwanted pregnancy or abortion [7].

For many years, Ipas, working together with the Honduran Ministry of Health, has been training healthcare providers in MVA as a means of promoting the use of this technique. A study on abortion that was also

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part of the SGOH's plan of action [8] found that difficulties in obtaining MVA kits or lack of these kits constituted the main barrier to increasing the use of this method. Another barrier to improving postabortion care was that social pressure from civil institutions practically forced the healthcare personnel at public institutions to discriminate against women requesting postabortion care.

For these reasons, SGOH requested emergency funds from the FIGO Working Group to enable them to purchase MVA kits, which were then distributed to healthcare facilities throughout the country. It was also deemed necessary to train all healthcare personnel working in postabortion care on abortion values clarification and confidentiality. The present paper presents the results of these interventions regarding the use of MVA instead of sharp curettage for the treatment of incomplete abortion in a number of hospitals in Honduras.

2. Materials and methods

Since Honduras is considered a priority country in the FIGO initiative in the Central American and Caribbean region, it is entitled to receive emergency funding to enable it to carry out the activities included in its plan of action. The SGOH requested these emergency funds for the purpose of purchasing 250 MVA kits, which would then be distributed nationwide by the Ministry of Health. The kits were distributed to 25 public hospitals (Table 1) in February 2012 with the objective of increasing MVA use for the treatment of incomplete abortion within the public health care system.

Once the kits acquired with the emergency funds were distributed, the Ministry of Health conducted training workshops for participating hospital personnel on pre- and postprocedure counseling in accordance with the new official guidelines. Workshops on pain management and on MVA were also offered.

A Training of Trainers (TOT) course consisting of values clarification exercises was carried out to ensure that prepared instructors were in place at each participating hospital to disseminate the information received during the course to other local healthcare personnel. This is a course originally created by Ipas to enhance awareness of participants' personal values with regard to abortion and how these values influence the way in which they deal with women in their care. As a result of this 3-day TOT course, conducted with technical support from Ipas and financial support from FIGO, 30 obstetricians and nurses from 23 hospitals were trained as trainers.

Table 1
Distribution of manual vacuum aspiration (MVA) kits.

No.	Hospital	MVA kits		
		RAMNI/AECID		FIGO/SOGH
		Delivered	Scheduled	Scheduled
1	Atlántida	5		20
2	Tela Integrado	10		10
3	Tocoa	5		5
4	Trujillo		5	5
5	Comayagua	5		10
6	Occidente	5		5
7	Cortes		5	5
8	Choluteca		5	5
9	El Paraíso	5		5
10	Gracias a Dios		5	5
11	Intibucá		5	10
12	Roatán	5		10
13	La Paz (Suazo Córdova)	5		10
14	Lempira (Juan M. Galvez)	5		10
15	Ocotepeque	5		10
16	San Francisco (Olancho)	5		5
17	Santa Bárbara	5		10
18	Valle (San Lorenzo)	5		10
19	El Progreso		5	5
20	Olanchito		5	5
21	Yoro (subirana)		5	5
22	Escuela	25		30
23	San Felipe			
24	Mario C. Rivas	10		30
25	Leonardo Martínez		5	5
	Extra kits			20
Total		105	45	250

3. Results

Some of the most important results attributable to the FIGO initiative in Honduras are discussed below.

3.1. Collaboration between SGOH and the Ministry of Health was strengthened and became more effective

One of the requirements of this initiative is the active involvement of the Ministry of Health in elaborating and carrying out the country's plan of action. In Honduras, the SGOH and representatives of the Ministry of Health worked closely together and collaborated toward successfully achieving some of the goals established in the plan of action regarding service provision, research, and continued medical education.

3.2. Highlighting the problem of unsafe abortion

The FIGO member associations taking part in this initiative have committed to including the subject of unsafe abortion and its consequences in national and regional congresses. This has increased the exposure of SGOH members to this issue, highlighting the problem and humanizing it. For the first time, at the most recent congress of the Latin American Federation of Obstetrics and Gynecology Societies (FLASOG), at least 7 sessions dealt with this subject.

3.3. Changes in MVA use

The changes in MVA use have been quite disappointing. First, only 11 of the 25 hospitals that received the kits were able to provide data on the number of women who benefited from the availability of MVA in the respective hospitals. MVA use increased slightly from 2011 to 2012 in 6 of the 11 hospitals that provided data for evaluation and decreased slightly in the remaining 5 hospitals. Overall, taking the entire set of 11 hospitals into consideration, MVA use increased from 71.1% to 77.1% between 2011 and 2012 (Table 2).

The trends were particularly unfavorable between 2012 and 2013, when MVA use increased in only 3 of the 11 hospitals and decreased in 8, dropping to below 2011 levels in 7 of these cases. Taking the entire group of 11 hospitals into consideration, the percentage of MVA use fell below 70%, i.e. below the 2011 level (Table 2).

Table 3 compares the number of procedures reported with the possible number achievable with the kits provided, considering 50 procedures per kit as optimal.

All of the hospitals in which there was an improvement, with the exception of Tela, and those in which there was no significant change, with the exception of Atlántida, reported having performed more procedures than expected with the number of kits allotted to them, and had used up all their kits by the end of 2012.

In the group in which the percentage of MVA use decreased, 3 very different situations were found in the 3 different hospitals: (1) in the San Marcos Ocotepeque Hospital, enough kits were available and MVA use was acceptable; however, use decreased consistently over the 3 evaluation periods; (2) in Progreso Hospital, use of the kits was high; however, overall MVA use was low and decreased consistently over the 3 evaluation periods; and (3) in Roatan, too many kits were provided and the percentage of MVA use was acceptable; however, there was a trend toward a more accentuated decrease in 2013. In these hospitals, the availability of trained personnel and the provision of kits should be reviewed in accordance with the number of procedures reported.

Table 2
Changes in manual vacuum aspiration (MVA) use in the 11 hospitals that provided data on the number of women benefiting from the availability of MVA kits.

No.	Hospital	Kits provided	Percentage MVA			Trend
			2011	2012	Jan—Jun 2013	
1	San Lorenzo	10	228/275 83%	269/321 84%	109/133 82%	No change
2	La Paz	10	243/280 87%	246/304 81%	151/178 85%	No change
3	Escuela	30	1580/1697 93%	1421/1586 90%	574/591 97%	Overall improvement
4	Mario Catarino Rivas	30	1672/2168 77%	1769/2179 81%	911/1196 76%	Improved in 2012. No overall change
5	Atlántida	20	248/840 30%	119/300 40%	114/414 28%	Improved in 2012. No overall change
6	Gracias a Dios	5	150/218 69%	181/250 72%	153/194 79%	Improved
7	Santa Bárbara	10	247/264 94%	339/345 98%	189/191 99%	Improved
8	Tela	10	8/378 2%	56/369 15%	7/141 5%	Improved in 2012
9	Ocotepeque	10	189/251 75%	180/261 69%	96/168 57%	Decreased
10	Roatan	10	95/110 86%	113/135 84%	39/51 76%	Decreased
11	Progreso	5	293/487 60%	70/128 55%	70/270 30%	Decreased
	Total		4953/6968 71%	4763/6178 77%	2413/3527 68%	

To gain a better understanding regarding what was happening in these hospitals, officials from the Ministry of Health conducted a short e-mail and telephone survey. The results of this survey are shown in Table 4.

Of the hospitals in which no change occurred, the main reasons given for not having achieved any further improvement were the need for more MVA kits (87%) and a need for trained personnel (53%). The hospitals in which an improvement was seen stated that they needed more training in pain control (67%) and more kits (56%).

In the hospitals in which the percentage of MVA use decreased, the main reason given was a need for trained personnel (78%) and better pain control techniques (67%). As a secondary reason, these hospitals reported that the medical personnel were reluctant to change from the routinely used sharp curettage to MVA (56%).

For the group as a whole, the main obstacles to increasing MVA use are a need for trained personnel and the provision of enough kits to meet demand. An additional hurdle to be overcome concerns the reluctance of some medical personnel to abandon curettage and start using MVA.

4. Discussion

The FIGO initiative was launched in 2007 to prevent the practice of unsafe abortion and its consequences [9]. Replacing the traditional use of sharp curettage with MVA for the treatment of incomplete abortion has been established as an objective in 26 of the 43 participating countries [10]. Honduras is one of these countries and by including this objective and using the allotted emergency funds to acquire the necessary MVA kits, it was possible to distribute MVA kits to 25 public hospitals located throughout the country. The results obtained show no overall improvement in the percentage of MVA use as a result of the distribution of these kits; however, the main hospitals that were already using MVA in a high percentage of cases were able to continue doing so thanks to this donation. The optimistic belief that distributing MVA kits and training physicians would increase the use of MVA rather than sharp curettage in the public hospitals in Honduras in general was unfounded and, in fact, the results of this study suggest the opposite. Although the lack of data from 14 of the 25 hospitals that received kits does not permit any definitive conclusions to be drawn for the country as a whole, there is no reason to believe that the hospitals for which no data were available performed any better than those for which data were available. Despite that limitation, the Honduran experience serves as a good example of the importance of objectively evaluating any intervention to verify whether the expected effect was achieved, to identify the reasons for not having achieved the expected outcome, and to implement any changes that may be required.

Table 3
Number of procedures reported compared with the possible number achievable with the kits provided.

No.	Hospital	Kits provided	Procedures			Kit situation	% kit use	% Overall MVA use
			Possible	Reported 2011 and 2012	Total			
1	San Lorenzo	10	500	497	606	Used all	121	83
2	La Paz	10	500	489	640	Used all	128	84
3	Escuela	30	1500	3001	3575	Used all	238	92
4	Gracias a Dios	5	250	331	484	Used all	193	73
5	Mario Catarino Rivas	30	1500	3441	4352	Used all	290	79
6	Ocotepeque	10	500	369	465	Left over	93	68
7	Santa Barbara	10	500	586	775	Used all	155	97
8	Roatan	10	500	208	247	Left over	49	83
9	Tela	10	500	64	71	Left over	14	8
10	Atlántida	20	1000	367	481	Left over	48	31
11	Progreso	5	250	363	433	Used all	173	49
	Total	150	7500	9416	11 829		157	67

Table 4
Expressed agreement or disagreement with a list of reasons that could explain the trend in manual vacuum aspiration use.[a]

Hospital	Reasons that may explain the trend in the proportion of cases treated with MVA						
	Proportion of MVA use is already high	Not enough trained providers	Poor pain control	Unwilling to change	Lack support from hospital authorities	MVA linked to abortion	Need more kits
Hospitals in which the use of MVA did not change							
San Lorenzo	0	3	0	0	0	0	3
La Paz	2	2	0	2	0	0	2
Escuela	3	0	0	0	0	0	3
Mario Catarino Rivas	2	1	0	2	0	0	2
Atlántida	0	2	0	0	0	0	3
Subtotal	7/15	8/15	0	4/15	0	0	13/15
	47%	53%		27%			87%
Hospitals in which the use of MVA improved							
Gracias a Dios	0	0	0	1	0	2	3
Santa Bárbara	0	0	3	0	0	1	2
Tela	0	3	3	3	0	0	0
Subtotal		3/9	6/9	4/9		3/9	5/9
		33%	67%	44%		33%	56%
Hospitals in which the use of MVA decreased							
Ocotepeque	0	1	0	2	0	0	0
Roatan	0	3	3	2	0	2	0
Progreso	0	3	3	3	0	NR	0
Subtotal		7/9	6/9	5/9		2/9	
		78%	67%	56%		22%	
Total	7/33	18/33	12/33	15/33	0	5/33	18/33
	21%	54%	36%	45%		15%	54%

[a] Score: 0 = Disagreement; 1 = Partial disagreement; 2 = Partial agreement; 3 = Agreement. NR = not reported.

In the specific case of substituting sharp curettage with MVA, one of the most important obstacles in Honduras appears to be the doctors' reluctance to change from their traditional use of sharp curettage for the treatment of incomplete abortion. Although this reason for not increasing MVA use was not as common as a lack of training or an insufficient supply of MVA kits, it should be kept in mind that it is more difficult to blame one's colleagues than it is to blame other impersonal factors. In addition, lack of training may be one of the reasons why physicians feel more comfortable using sharp curettage, which they were trained to use as residents, rather than a new technology that they may not have mastered to the same extent.

In general, there is much less motivation to publish negative results than there is to publish positive ones; however, we believe that it is our duty to show that superficial observations may be misleading and that a more objective evaluation of actual numbers provides a more realistic picture. Only with accurate data at hand will it be possible to implement the changes that are required in this intervention to enable the expected results to be achieved. In this case, it is clear that greater commitment is required from the SOGH to adopt the FIGO recommendation to abandon sharp curettage and adopt MVA or misoprostol, as appropriate, for the treatment of incomplete abortion.

More training must be provided to personnel and a better monitoring system should be implemented that will identify and overcome barriers. In addition, the Ministry of Health needs to improve the distribution of commodities in accordance with the population seen and the procedures performed at each hospital, and the SOGH must play a role in influencing the Ministry of Health in that direction.

Many important lessons have been learned from the experience acquired in this joint initiative, the most important one being that providing commodities alone is an ineffective measure unless it is supported by a strong monitoring system that will ensure the rational use of these supplies and an overall improvement in the services provided.

Following this experience, the governmental authorities should commit to providing the necessary commodities and to ensuring sustainability. They must also strengthen and improve the section of their Reproductive Health Department that monitors postabortion care. Another important lesson learned is that activities aimed at sensitizing healthcare personnel need to be implemented to insure good quality postabortion care.

The general and regional coordination of the FIGO initiative should take the necessary steps to see that the issue of implementing modern treatment in cases of incomplete abortion becomes a frequent subject of debate in the national and regional congresses of the specialty and that the document containing the FIGO recommendations is more broadly disseminated, increasing the knowledge of our colleagues in Honduras and in the rest of the Central American and Caribbean region on this subject.

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Conflict of interest

The authors have no conflicts of interest.

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